Commonwealth of Virginia

REQUEST FOR PROPOSAL

Issue Date: December 5, 2011

Issue Title: **Preparation of Medicaid/Medicare Annual Cost Reports**

Issuing Agency: Department of Behavior Health and Developmental Services (DBHDS) - P.O. Box 1797, Richmond, Virginia 23218-1797

Using Agency and Location Where Work Will Be Performed: DBHDS - Statewide

Period of the Contract: July 1, 2012 through June 30, 2013.

Renewals: Contract may be renewed for five (5) additional periods of one (1) year duration upon mutual agreement between all parties and subject to availability of funding.

Proposals will be received for furnishing services described herein until:

Wednesday – January 11, 2012 - 1:00 PM EST

All inquiries for information shall be directed to:

Proposal Preparation and General Procedural Queries:	Dick Myers 804-786-6632
Copies of RFP:	

NOTE: **Vendors who expect to submit proposals in response to this solicitation are requested to return Form 1 – Intention to Respond via fax to 804-786-3827 no later than close of business on December 19, 2011.**

To ensure that all questions receive responses, interested vendors are requested to submit questions via email to dick.myers@dbhds.virginia.gov and include e-mail address, voice and fax phone numbers by no later than 3:00 pm EST on December 21, 2011.

No other questions will be responded to after the December 21, 2011 deadline.

May be obtained at www.dbhds.virginia.gov Click on link to Procurement/Solicitations and then click on link to Solicitations for the Office of Administrative Services and look for solicitation number assigned.

Proposal Delivery Information:

All Proposals shall be addressed: **DBHDS, Office of Administrative Services.** If mailed, send to **P.O. Box 1797, Richmond, VA 23218-1797;** if hand delivered **Jefferson Building, 8th Floor - Room 817, 1220 Bank Street, Richmond, Virginia, 23219.** Envelopes should be marked with RFP number and opening date and time. It is the contractor's responsibility to assure that proposals are received and logged in by Procurement Operations staff at the location indicated by the date and time above, regardless of the method of delivery. LATE proposals will NOT be accepted under any circumstances. The above page and this signature page **must** accompany your proposal, with all information supplied and signatures applied as required.

IN COMPLIANCE WITH THE ABOVE REFERENCED REQUEST FOR PROPOSALS AND TO ALL THE CONDITIONS IMPOSED HEREIN, IN FACT OR BY REFERENCE, THE UNDERSIGNED OFFERS AND AGREES TO FURNISH THE SERVICES IN ACCORDANCE WITH THE ATTACHED SIGNED PROPOSAL OR AS MUTUALLY AGREED UPON BY SUBSEQUENT NEGOTIATION.

Offeror Name and Address:

_____ **Date:** _____

_____ **By:** _____
(Official Signature in Ink)

_____ **Printed**

Telephone: _____ **Name:** _____

FEI/FIN Number: _____ **Title:** _____

The following information is requested, but it is not mandatory that it be supplied. Minority status does not influence the award: (Please Check all that apply)

	Contractor DOES consider his/her firm to be a minority business.
	Contractor does NOT consider his/her firm to be a minority business
	Contractor IS certified as a minority business by VA Department of Minority Business Enterprise.
	Contractor is NOT certified as minority business by VA Department of Minority Business Enterprise.
	Contractor is a eVA registered vendor. (Learn about eVA at www.eva.state.va.us)
	Contractor is NOT a eVA registered vendor.
	STATE CORPORATION COMMISSION IDENTIFICATION NUMBER: _____

FORM 1 – INTENTION TO RESPOND
RFP #720C-04325-12D00
No Fax Cover Sheet Is Required

FAX BACK: Your assistance is requested. Please fax back by no later than **December 19, 2011**.

TO: Office of Administrative Services (Attn: Dick Myers) - Virginia Department of Behavioral Health and Developmental Services, Richmond, Virginia 23218

FAX TO: 804-786-3827

The organization below (check any that apply):

☐ Intends to prepare and submit a proposal to the above referenced solicitation.

Our contact person will be: _____

Contact voice phone number is: _____

Contact fax number is: _____

Contact e-mail address: _____

☐ Does NOT intend to respond to the above referenced solicitation.

☐ Other message: _____

_____

Company Name: _____

Person Responding: _____

Voice Phone: _____ Fax: _____

1.0 Purpose

The purpose of this Request for Proposal (RFP) is to solicit offers from qualified individuals or organizations for licensing rights for a Centers for Medicare & Medicaid Services (CMS) approved software (Attachment A) to be used for preparation of the electronic submission of the annual Medicare/Medicaid Cost Reports (9 electronic submissions for 31 Providers) for the fiscal year ended June 30, 2012 and beyond.

The desired results of this contract are:

- Licensing rights for use of a CMS approved software for preparation of electronic submissions;
- Installation or continued maintenance of software at ten (10) locations;
- Appropriate and necessary training in use of software for staff at each location;
- Annual analytical reviews for Revenue Maximization;
- Technical assistance and updates to the software based on changes in regulations and reimbursement requirements; and
- Unlimited technical assistance from the awarded contractor.

1.1 BACKGROUND INFORMATION

The Department of Behavioral Health and Developmental Services (DBHDS), hereinafter referred to as the Purchasing Agency, provides behavioral health, developmental disability and substance use disorder to Virginians through a system of state operated facilities.

The Purchasing Agency operates nine (9) adult mental health facilities, one (1) child and adolescent mental health facility, five (5) training centers and one (1) acute medical center that provides in-patient general medical, skilled and nursing care, with a combined total operating budget for FY 2011 of **$578,555,398**.

Facilities administered by Purchasing Agency are public nominal charge providers that utilize an all-inclusive charge structure, and also, utilize "Method A" (Attachment "B") for cost apportionment.

- Twelve (12) facilities with a combined total of thirty-four (34) certified levels of care (Providers) participate in the Medicare and/or Medicaid Program and a current total of 2,969 certified beds consisting of Medical/Surgical (45), Skilled Nursing (167), Intensive Psychiatric Treatment (501), Chronic Disease (364), Intermediate Care Facility-General (195), and Intermediate Care Facility - Mental Retardation (1697).

- All Medicaid providers are cost settled on the Lower of Cost or Charges Basis of Reimbursement and consist of the following:

  Number of Certified Providers

Medical/Surgical (Acute Hospital)	5
Skilled Nursing Facility	2
Intensive Psychiatric Treatment	3

Intermediate Care Facility (Nursing Facility)	3
Chronic Disease	2
Intermediate Care Facility - Mental Retardation	5

- The Medicare providers, effective July 1, 2011 are to be reimbursed as Prospective Payment System Providers and consist of the following:

Number of Certified Providers

Medical/Surgical (PPS)	5
Skilled Nursing Facility (PPS)	2
Intensive Psychiatric Treatment	5
Chronic Disease	2

The Purchasing Agency's Cost Accounting System was installed in the late 1960's primarily to meet Medicare and Medicaid financial reporting requirements. In 1984 the Purchasing Agency purchased a financial management software package, designed specifically and exclusively for the Purchasing Agency's Hewlett Packard 3000 Computer System, which included cost accounting and report writing capabilities. The Purchasing Agency also utilizes Windows 2000 and XP Professional Operating Systems.

For your information a schedule is enclosed, **(Attachment C)** which identifies the volume of Medicare and Medicaid utilization, applicable to Fiscal Year 2011, by each certified participating facility.

1.2 Participation of Small Businesses and Businesses owned by Women and Minorities: It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in State procurement activities. Toward that end, the Commonwealth encourages contractors to provide for the participation of minority, women-owned and small businesses and businesses through partnerships, joint ventures, subcontracts, or other contractual opportunities. Please indicate in Attachment D to this proposal the type and amount of subcontracting you propose if awarded this contract. The quarterly reporting of such subcontracting, joint ventures, etc. shall be a requirement of any contract resulting from this solicitation. Therefore, the successful contractor(s) shall submit a "Contractor's Report on Subcontracting" to the Contracting Agency within fifteen days after the end of each quarter during the term of the resulting contract and any subsequent renewal. This report shall be submitted even if there has been no applicable subcontracting during the preceding calendar quarter.

2.0 SCOPE OF WORK - MANDATORY REQUIREMENTS

The Contractor(s) shall provide all labor, supplies, travel and transportation to accomplish the following mandatory requirements:

2.1 Coordinate the gathering of all expense, revenue and statistical data for the Medicare and Medicaid cost reports from the facilities and the Central Office. This should be accomplished utilizing **Windows 2000 and/or XP Professional** and compatible with future Microsoft Operating Systems upgrades to generate input discs (at the general ledger level of detail) that are facility specific.

2.2 Provide any necessary training of personnel, identified by the Purchasing Agency, in the use of a CMS approved Windows based software package for in-house preparation of cost reports at the ten (10) DBHDS locations.

2.3 Analyze the preliminary reports for regulatory compliance to determine if the settlements encompass appropriate reimbursement maximization strategies.

2.4 Provide unlimited as requested on-site (Central Office) reviews with personnel in regard to:

2.4.1 The preliminary settlement and to assist the Central Office with investigation of specific questions/issues about each facility's reports;

2.4.2 Revisions to draft settlements based on the Central Office's internal review of data after the preliminary report has been received from the facilities;

2.4.3 Revisions to settlements based on the Central Office's internal review of data after the original report has been submitted to the Intermediary;

2.4.4 Revisions based on the findings of the Commonwealth's Auditor of Public Accounts; and

2.4.5 Revisions based on the fiscal intermediary's pre-tentative adjustments.

2.5 Production of the final Medicare and Medicaid cost reports for submission to PalmettoGBA (Medicare Intermediary) and the Department of Medical Assistance Services (Medicaid Intermediary) meeting deadline requirements established by the Purchasing Agency, and not necessarily the Program intermediary. The Contractor shall be required to provide an unlimited number of reruns, at no extra cost, until the report is finalized. Such reruns must be received by DBHDS Central Office within twenty-four (24) hours of the provision of revised information. In addition, the contractor must be available at a later date for defending, consulting, and revising reports, should such reports be subject to a CMS audit, at no additional charge.

2.6 The Contractor shall be prepared to work on-site at as many facilities and Central Office as are considered necessary by the Purchasing Agency to complete this project. The Contractor will be responsible for working with staff of the Purchasing Agency in order to collect the necessary data, arrange travel, and provide for any additional support services.

2.7 The software package provided must be available and capable of being used to prepare "what if" models.

2.8 The Contractor shall provide off-site storage and backup copies of all filed reports.

3.0 STANDARDS OF PERFORMANCE:

3.1 Contractor shall comply with all regulations and requirements of CMS formerly, The Health Care Financial Administration (HCFA).

4.0 QUALIFICATIONS OF THE PROVIDER:

Only those providers whose firm has developed and/or is the proprietor of a CMS approved Electronic Cost Report (ECR) software system who have at a minimum five (5) or more years experience in conducting such services and who posses a qualified trained staff shall be considered. If not the developer, Offerors must submit a letter from the proprietor authorizing their use of the software.

Offerors shall exhibit strong fiscal responsibility and good accounting practices. Offerors shall be professional individuals or firms currently engaged in the practice of Health Care Financial Management and/or Reimbursement.

5.0 PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS:

General Instructions:

5.1 **RFP Response:** In order to be considered for selection Offerors must submit a complete response to this RFP. **One (1) original and four (4) copies must be submitted to the DBHDS**. No other distribution of the proposal shall be made by the Offeror.

5.2 **Proposal Preparation:** Proposals shall be signed by an authorized representative of the Offeror. All information requested should be submitted. Failure to submit all information requested may result in the Purchasing Agency requiring prompt submission of missing information and/or giving a lowered evaluation of the proposal. Proposals which are substantially incomplete or lack key information may be considered non-responsive and be rejected by the Purchasing Agency. Mandatory requirements are those required by law or are such that they cannot be waived and are not subject to negotiation.

Proposals should be prepared simply and economically, providing a straightforward, concise description of capabilities to satisfy the requirements of the RFP. Emphasis should be on completeness and clarity of content.

Proposals should be organized in the order in which the requirements are presented in the RFP. All pages of the proposal should be numbered. Each paragraph in the proposal should reference the paragraph number of the corresponding section of the RFP. It is also helpful to cite the paragraph number, subletter, and repeat the text requirement as it appears in the RFP. If a response covers more than one page, the paragraph number and subletter should be repeated at the top of the next

page. The proposal should contain a table of contents which cross-references the RFP requirements. Information that the Offeror desires to present that does **not** fall within any of the requirements of the RFP should be inserted at an appropriate place or attached at the end of the proposal and designated as additional material. Proposals that are not organized in this manner risk elimination from consideration if the evaluators are unable to locate where the RFP requirements are specifically addressed.

As used in this RFP, the terms "must", "shall", "should" and "may" identify criticality or requirements. "Must" and "shall" identify requirements whose absence will have a major negative impact on the suitability of the proposed solution. Items labeled as "should" or "may" are highly desirable, although their absence will not have a large impact and would be useful, but are not necessary. Depending on the overall response to the RFP, some individual "must" and "shall" items may not be fully satisfied, but it is the intent to satisfy most, if not all, "must" and "shall" requirements. The inability of an Offeror to satisfy a "must" or "shall" requirement does not automatically remove that Offeror from consideration; however it may seriously affect the overall rating of the Offerors' proposal.

Each original of the proposal should be bound in a single volume.

Ownership of all data, materials and documentation originated and prepared for the State pursuant to the RFP shall belong exclusively to the State and be subject to public inspection in accordance with the *Virginia Freedom of Information Act*. Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the *Virginia Freedom of Information Act*; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and state the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and may result in rejection of the proposal.

5.3 Oral Presentation of Proposal: Offerors who submit a proposal in response to this RFP may be required to give an oral presentation of their proposal to the Purchasing Agency. At the Offeror's request these may be via telephone conference call. This will provide an opportunity for the Offeror to clarify or elaborate on the proposal but will in no way change the original proposal. Oral presentations are an option of the agency and may not be conducted.

5.4 Specific Requirements of Proposal: Proposals submitted in response to this RFP should be as concise as possible so that the DBHDS evaluation team may properly evaluate your capabilities to provide the required services. Offerors are required to submit the following items, in clearly labeled, sections, as a complete proposal:

5.4.1 The return of this complete RFP and all addenda acknowledgments, if any, signed and filled out as required.

5.4.2 A detailed narrative description of the services to be provided. Narrative should include a description of the proposed methodology in the preparation, analysis and production of cost reports (limited to three (3) pages).

5.4.3 Resumes of key individuals who shall be assigned to manage and carry out the services to be provided under any contract awarded as a result of this RFP, to include all training received

5.4.4 Detailed narrative regarding experience of Offeror to include; number of years experience individual/organization has as a developer and/or proprietor of a CMS approved Electronic Cost Report (ECR) software system, other projects/contracts of this type, including duration or period covered and references with contact name, address and phone number.

5.4.5 Time frame proposal with detailed indication of responsible key individuals addressed in 5.4.3 above and resource commitment for each task.

5.4.6 A Detailed narrative of any support required or expectations of the Purchasing Agency, including use of facilities, equipment and staff.

5.4.7 A detailed financial payment proposal.

6.0 EVALUATION AND AWARD CRITERIA

6.1 Proposals shall be evaluated by the DBHDS using the following criteria:

6.1.1 Documented proof of a CMS approved electronic software for submitting the CMS Form #2552-10 cost report applicable to fiscal year ending June 30, 2012. If approval has not been received, then proof that system has been submitted for approval.

6.1.2 Demonstrated experience of the Offeror in performing services as described in 5.4.4 above.

6.1.3 The Offeror's familiarity with healthcare issues and hospital cost reporting.

6.1.4 The extent of and degree of expertise of the Offeror's resource commitment.

6.1.5 Soundness of the Offeror's technical approach and workplan.

6.1.6 The Offeror's system of analysis reporting and requirements of the system on the Purchasing Agency.

6.1.7 Detailed financial and payment proposal.

6.1.8 Is Offeror certified by the Virginia Department of Minority Business Enterprise

6.2 **AWARD:** Selection shall be made of two or more Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors above. Negotiations shall be conducted with the Offerors so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror(s) which, in its sole opinion, has made the best proposal, and shall award the contract to that Offeror. The agency may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reason why a particular proposal was not deemed to be the most advantageous. (*Code of Virginia* § 2.2-4395D) Should the DBHDS determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms, and conditions of the solicitation and the Contractor's proposal as negotiated.

7.0 GENERAL TERMS AND CONDITIONS:

7.1 **CONTRACTUAL DISPUTES:** Contractual claims, whether for money or other relief, shall be submitted in writing no later than sixty (60) days after final payment. Written notice of the Contractor's intention to file such claim shall be given at the time of the occurrence or beginning of the work upon which the claim is based. The contract may require submission of an invoice for final payment within a certain time after completion and acceptance of the work. Pendency of claims shall not delay payment amounts agreed due in the final payment.

The claim shall be filed with the Administrative Services Director setting forth the factual basis for the claim. The Administrative Services Director shall review the claim and notify the Contractor of the decision by certified mail within fifteen (15) days of receipt. The notification shall set forth the reasons for the decision and inform the Contractor that they may request a review of the decision by the Commissioner by filing such request within ten (10) days of receipt of the initial decision. The Commissioner may convene a panel to advise on a decision. The Commissioner shall render a final decision setting forth the reasons for the decisions within thirty (30) days of receipt of the request for review.

The Contractor may not institute legal action prior to receipt of the Commissioner's decision on the claim as provided in § 2.2-4364 of the *Code of Virginia*, unless the Commissioner fails to render the decision within thirty (30) days of receipt of the claim.

Failure of the Administrative Services Director or Commissioner to render a decision within the time frames specified shall not have the effect of affirming or denying the claim, but shall only permit the Contractor to proceed to the next step in the process. (§ 2.2-4363 of the *Code of Virginia*).

7.2. **APPLICABLE LAW AND COURTS:** This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with

respect thereto shall be brought in the courts of the Commonwealth. The agency and the contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (Code of Virginia, § 2.2-4366). ADR procedures are described in Chapter 9 of the Vendor's Manual. The contractor shall comply with applicable federal, state and local laws and regulations.

7.3. **ANTI-DISCRIMINATION:** By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the Virginia Public Procurement Act (VPPA). If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (Code of Virginia, § 2.2-4343.1E).

In every contract over $10,000 the provisions in 8.3.1 and 8.3.2 below apply:

7.3.1 During the performance of this contract, the contractor agrees as follows:

7.3.1.1 The contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the contractor. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

7.3.1.2 The contractor, in all solicitations or advertisements for employees placed by or on behalf of the contractor, will state that such contractor is an equal opportunity employer.

7.3.1.3 Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

7.3.2. The contractor will include the provisions of 8.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

7.4. **ETHICS IN PUBLIC CONTRACTING:** By submitting their proposals, all Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

7.5. **IMMIGRATION REFORM AND CONTROL ACT OF 1986:** By submitting their proposals, the Offerors certify that they do not and will not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

7.6. **DEBARMENT STATUS:** By submitting their proposal, all Offerors certify that they are not currently debarred from submitting proposals on contracts by any agency of the Commonwealth of Virginia, nor are they an agent of any person or entity that is currently debarred from submitting proposals on contracts by any agency of the Commonwealth of Virginia.

7.7. **ANTITRUST:** By entering into a contract, the Offeror conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of the action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

7.8. **MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS:** Failure to submit a proposal on the official state form provided for that purpose may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, DBHDS reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

7.9 **CLARIFICATION OF TERMS:** If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact the contract officer whose name appears on the face of the solicitation, no later than seven days before the due date. Any revisions to the solicitation will be made only by addendum issued by the contract officer.

7.10 **PRECEDENCE OF TERMS:** The following General Terms and Conditions VENDORS MANUAL, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any

Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

7.11. **QUALIFICATIONS OF OFFEROR:** The DBHDS may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the work and the Offeror shall furnish to DBHDS all such information and data for this purpose as may be requested. DBHDS further reserves the right to reject any proposal if the evidence submitted by or investigations of such Offeror fails to satisfy DBHDS that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated herein.

7.12 **ASSIGNMENT OF CONTRACT:** A contract shall not be assignable by the contractor in whole or in part without the written consent of DBHDS.

7.13. **CHANGES TO THE CONTRACT:** Changes can be made to the Contract by written mutual agreement, signed by both parties.

7.14. **DEFAULT:** In case of failure to deliver good or services in accordance with the contract terms and conditions, DBHDS, after due oral or written notice, may procure them from other sources and hold the contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which DBHDS may have.

7.15 **INSURANCE:** By signing and submitting a proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverages at the time the contract is awarded. The Offeror further certifies that the Contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverages will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

INSURANCE COVERAGES AND LIMITS REQUIRED:

7.15.1 Worker's Compensation - Statutory requirements and benefits. Coverage is compensatory for employers of three or more employees, to include employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change workers' compensation requirements under the Code of Virginia during the course of the contract shall be in noncompliance with the contract.

7.15.2 Employers Liability - $100,000.

7.15.3 Commercial General Liability - $3,000,000 per occurrence single limit. Commercial General Liability is to include bodily injury, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional named insured and so endorsed on the policy.

7.15.4 Automobile Liability - $1,000,000 – per occurrence

7.16 **ANNOUNCEMENT OF AWARD:** Upon the award or the announcement of the decision to award a contract over $50,000, as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA web site (www.eva.state.va.us) for a minimum of 10 days.

7.17 **DRUG FREE WORKPLACE:** During the performance of this contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

7.18. **NONDISCRIMINATION OF CONTRACTORS:** An Offeror shall not be discriminated against in the award of this contract because of race, religion, color, sex, national origin, age, or disability or against faith-based organizations. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

7.19 **eVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION:** The eVA Internet electronic procurement solution, website portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet eprocurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or offerors must register in eVA and pay the Vendor Transaction Fees specified below; failure to register will result in the bid/proposal being rejected. Effective July 1, 2011, vendor registration and registration-renewal fees have been discontinued. Registration options are as follows:

a. eVA Basic Vendor Registration Service: eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.
b. eVA Premium Vendor Registration Service: eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

Vendor transaction fees are determined by the date the original purchase order is issued and are as follows:

a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.
b. For orders issued August 16, 2006 thru June 30, 2011, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.
c. For orders issued July 1, 2011 thru June 30, 2012, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 0.75%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 0.75%, capped at $1,500 per order.
d. For orders issued July 1, 2012 and after, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, approximately 30 days after the corresponding purchase order is issued and payable 30 days after the invoice date. Any adjustments (increases/decreases) will be handled through purchase order changes.

7.20 PAYMENT:

7.21.1 To Prime Contractor:

Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number, social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).

7.20.1.1 Any payment terms requiring payment in less than 30 days shall be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.

7.20.1.2 All goods or services provided under this contract or purchase order,

that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.

7.20.1.3 The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act

7.20.1.4 **Unreasonable Charges:** Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Purchasing Agency shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an Agency of its prompt payment obligations with respect to those charges which are not in dispute (*Code of Virginia*, ' 2.2-4363).

7.20.2 To Subcontractors:

A Contractor awarded a contract under this agreement is hereby obligated:

7.20.2.1 To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Purchasing Agency for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

7.20.2.1 To notify the Agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

7.20.2.1 The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Purchasing Agency, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier contractor performing under the primary contract. A Contractor's

obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

7.21 **TESTING AND INSPECTION:** The DBHDS reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

8.0 SPECIAL TERMS AND CONDITIONS:

8.1. ADVERTISING: In the event a contract is awarded for supplies, equipment, or services resulting from this proposal, no indication of such sales or services to the DBHDS will be used in product literature or advertising. The contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services.

8.2 AUDIT: The contractor shall retain all books, records, and other documents relative to this contract for five (5) years after final payment, or until audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents, and/or state auditors shall have full access to and the right to examine any of said materials during said period.

8.3 AVAILABILITY OF FUNDS: It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

8.4 CANCELLATION OF CONTRACT: The purchasing agency reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 60 days written notice to the contractor. In the event the initial contract period is for more than 12 months, the resulting contract may be terminated by either party, without penalty, after the initial 12 months of the contract period upon 60 days written notice to the other party. Any contract cancellation notice shall not relieve the contractor of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

8.5 PRIME CONTRACTOR RESPONSIBILITIES: The contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that he may utilize, using his best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime contractor. The contractor agrees that he is as fully responsible for the acts and omissions of his subcontractors and of persons employed by them as he is for the acts and omissions of his own employees.

8.6 SUBCONTRACTS: No portion of the work shall be subcontracted without prior written consent of the purchasing agency. In the event that the contractor desires to subcontract some part of the work specified herein, the contractor shall furnish the purchasing agency the names, qualifications and experience of their proposed subcontractors. The contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

8.7 RENEWAL OF CONTRACT: This contract may be renewed by the Purchasing Agency upon written agreement of both parties for five (5) additional periods of up to one year duration under the terms and conditions of the original contract except as stated in 1. and 2. below. Price increases may be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew shall be given approximately 30-90 days prior to the expiration date of each contract period.

1. If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price(s) for the additional one year shall not exceed the contract price(s) of the original contract increased/decreased by more than the percentage increase/decrease of the "other services" category of the CPI-U section of the Consumer Price Index - of the United States Bureau of Labor Statistics for the latest twelve (12) months for which statistics are available as of the date of renewal.

2. If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not exceed the contract price(s) of the previous renewal period increased/decreased by more than the percentage increase/decrease of the "other services" category of the CPI-U section of the Consumer Price Index - of the United States Bureau of Labor Statistics for the latest twelve (12) months for which statistics are available as of the date of renewal.

8.8 IDENTIFICATION OF PROPOSAL ENVELOPE: The signed proposal should be returned in a separate envelope or package, sealed and identified as follows:

From: _____

Name of Offeror Due Date Time

Street or Box Number _____

City, State, Zip Code _____

RFP Title _____ RFP Number _____

Name of Contract/Purchase Officer _____

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other Proposals should be placed in the envelope.

8.9 AUTHORITIES: Nothing in this agreement shall be construed as authority for either party to make commitments which will bind the other party beyond the Scope of Work contained herein. Furthermore, the Contractor shall not assign, sublet, or subcontract any work related to this agreement or any interest he/she/it may have herein without the express written consent of the Contracting Agency, except as specified herein.

8.10 NONDISCRIMINATION OF CONTRACTORS: An offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

8.11 CONTRACT MANAGEMENT AND ADMINISTRATION: A primary contract administrator will be appointed by the Contracting Agency who will be responsible for monitoring and evaluating contractor performance. Only the DBHDS Office of Administrative Services may authorize any changes to the contract that modify, in a material fashion, the cost, terms and conditions, scope of work or delivery of services to be provided under the contract.

8.12 OWNERSHIP OF INTELLECTUAL PROPERTY: All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Commonwealth. On request, the contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

8.13 LATEST SOFTWARE VERSION: Any software product(s) provided under the contract shall be the latest version available to the general public as of the due date of this solicitation.

8.14 LIMITATION OF USE: The Commonwealth's right to use computer software developed entirely at private expense may be limited by the contractor as stipulated in this contract. Notwithstanding any provision to the contrary however, the Commonwealth shall have at a minimum: unlimited use of the software on the equipment for which it is purchased; use of the software on a secondary system for backup purposes should the primary system become unavailable, malfunction, or is otherwise rendered inoperable; use of the software at another Commonwealth site should the system be entirely transferred to that location; the right to make a backup copy for safekeeping; the right to modify or combine the software with other programs

or materials at the Commonwealth's risk; and the right to reproduce any and all documentation provided such reproduction is for the sole use of the Commonwealth. These rights are perpetual and irrevocable; in the event of any actual or alleged breach by the Commonwealth, the contractor's sole remedy shall be to pursue a monetary claim in accordance with § 2.2-4363 of the *Code of Virginia.*

8.15 PRODUCT SUBSTITUTION: During the term of any contract resulting from this solicitation, the vendor is not authorized to substitute any item for that product and/or software identified in the solicitation without the prior written consent of the contracting officer whose name appears on the front of this solicitation, or their designee.

8.16 SOFTWARE DISPOSITION: Unless otherwise instructed by the contractor, the Commonwealth shall render unusable all copies of software acquired under the contract within thirty (30) days of termination of its license, except that the Commonwealth does reserve the right to retain one copy of the software for archival purposes when appropriate.

8.17 TITLE TO SOFTWARE: By submitting a bid or proposal, the bidder or offeror represents and warrants that it is the sole owner of the software or, if not the owner, that it has received all legally required authorizations from the owner to license the software, has the full power to grant the rights required by this solicitation, and that neither the software nor its use in accordance with the contract will violate or infringe upon any patent, copyright, trade secret, or any other property rights of another person or organization.

8.18 Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder:

Except as otherwise limited in this contract, contractor may use or disclose protected health information (PHI) to perform functions, activities, or services for, or on behalf of, the Department of Behavioral Health and Development Services (DBHDS) as specified in this contract. In performance of contract services, Contractor agrees to:

- Not use or further disclose protected health information (PHI) other than as permitted or required by the terms of this contract or as required by law;
- Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this contract;
- Report to the DBHDS any use or disclosure of PHI not provided for by this Contract of which it becomes aware;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of DBHDS as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164 and the American Recovery and Reinvestment Act (P.L. 111-5) when effective;

- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it;

- Report to the DBHDS any security incident of which it becomes aware.

- Contractor shall notify DBHDS of a breach of unsecured PHI on the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide DBHDS with any other available information at the time Contractor makes notification to DBHDS or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes individuals should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches.

  For purposes of this paragraph, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the individual.

- Impose the same requirements and restrictions contained in this contract on its subcontractors and agents to whom contractor provides PHI received from, or created or received by a contractor on behalf of the DBHDS;

- Provide access to PHI contained in a designated record set to the DBHDS, in the time and manner designated by the DBHDS, or at the request of the DBHDS, to an individual in order to meet the requirements of 45 CFR 164.524.

- Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the DBHDS;

- Document and provide to DBHDS information relating to disclosures of PHI as required for the DBHDS to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528;

- Make its internal practices, books, and records relating to use and disclosure of PHI received from, or created or received by a contractor on behalf of DBHDS, available to the Secretary of the U.S. Department of Health and Human Services Secretary for the purposes of determining compliance with 45 CFR Parts 160 and 164, subparts A and E;

- At termination of the contract, if feasible, return or destroy all PHI received from, or created or received by a Contractor on behalf of the DBHDS that the contractor still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

  Contractor may use or disclose PHI received from the DBHDS, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Contractor may disclose PHI for such purposes if the disclosure is required by law, or if contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law of for the purpose for which it was disclosed to the person, and that person will notify the contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

8.19 **STATE CORPORATION COMMISSION IDENTIFICATION NUMBER:** Pursuant to Code of Virginia, §2.2-4311.2 subsection B, a bidder or offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its bid or proposal the identification number issued to it by the State Corporation Commission (SCC). Any bidder or offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its bid or proposal a statement describing why the bidder or offeror is not required to be so authorized. Indicate the above information on the SCC Form provided. Contractor agrees that the process by which compliance with Titles 13.1 and 50 is checked during the solicitation stage (including without limitation the SCC Form provided) is streamlined and not definitive, and the Commonwealth's use and acceptance of such form, or its acceptance of Contractor's statement describing why the bidder or offeror was not legally required to be authorized to transact business in the Commonwealth, shall not be conclusive of the issue and shall not be relied upon by the Contractor as demonstrating compliance.

Note: Please contact the Virginia State Corporation Commission Clerk's Office, at (804) 371-9733 or toll-free in Virginia at 1-866-722-2551, for detailed information of how to comply with the requirements of Special Condition 8.19.

Attachment A – RFP # 720C-04325-12D00
APPROVED CMS VENDOR LISTING

VENDOR LISTING FOR CMS'S COST REPORTS AS OF THE LATEST TRANSMITALS

For cost reporting periods beginning on or after 05/01/2010

VENDOR	CONTACT	TEL. NO.	FAX NO.	ADDRESS	COST REPORTS
Health Financial Systems becky@hfssoft.com	Becky dolin	(916)686-8152	(916)685-1699	8109 Laguna Blvd. Elk Grove, CA 95758	HOSPITAL 2552-10 T1&T2
KPMG LLP Dfry@KPMG.com	Don Fry	(818)227-6936	(818)227-6047	355 S. Grand Avenue, Suite 2000 Los Angeles, CA 90071	HOSPITAL 2552-10 T1&T2

HEALTH INSURANCE FOR THE AGED PROVIDER REIMBURSEMENT MANUAL

2100. PRINCIPLE

All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries or, in the case of acute care hospitals, the prospective payment system (PPS). (See Chapter 28 on PPS.) Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered, and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.--These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs Not Related to Patient Care.--Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Such costs are not allowable in computing reimbursable costs and include, for example:

- Cost of meals sold to visitors;
- Cost of drugs sold to other than patients;
- Cost of operation of a gift shop;

2150. HOME OFFICE COSTS--CHAIN OPERATIONS

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§1002.2 and 1002.3 for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where §1010 is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in §2153.

Section 2150 is not applicable to franchise fees (see §2135ff), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see §1010).

2150.1 General Limitation on Allowability of Costs.--Where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are subject to the provisions of chapter 10. Thus, allowable cost is limited to the lower of (1) allowable costs properly allocated to the provider, except as indicated in §1010, or (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chainwide basis.

2150.2 Determination of Allowable Costs.--

A. General.--Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable (see §2102.1). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see §2136.2), some franchise taxes and other similar taxes (see §2122.4), costs of noncompetition agreements (see §2105.1), certain life insurance premiums (see §2130), certain membership costs (see §§2138.3 and 2138.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner of the provider, as defined in chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see §902.2) and to the extent that it is reasonable (see §902.3).

B. Organization, Start-Up, and Other Corporate Costs.--

1. Organization Costs.--The organization costs of a home office (except those referred to below) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in §2134ff. Section 2134.1B describes costs which are not considered allowable organization costs. In addition, reorganization costs (see §2134.10) and stockholder servicing costs (see §2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.

2. Start-Up Costs.--Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of §2132ff.

3. Costs of Corporate Acquisitions.--Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see §2134.11). Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset (see §104.10).

C. Interest on Loans Between Home Office and Components of Chain.--Where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense. (See §218 for the general rule and §§218.2 and 220 for exceptions to the general rule.)

2156. ALLOWABLE COSTS OF GOVERNMENTAL SUPPORT SERVICES TO STATE AND LOCAL GOVERNMENTAL PROVIDERS

Agencies and departments of State and local governments often furnish providers operated by such government with facilities and services necessary to the operation of those providers. These facilities and services included such items as motor pool, legal counsel, procurement personnel administration, data processing payroll, maintenance and operation of plant, accounting, budgeting, auditing, and mail and messenger services. The costs of such facilities and services are includable in the allowable costs of the provider to the extent they are (l) reasonable, (2) related to patient care, (3) allowable under Medicare regulations, and (4) allocated on an acceptable basis.

Allowable services may also include an allocable share of supportive and supervisory time directly present in furnishing the service to the provider. They should not include supervision of a general nature such as that of a department head or staff assistants not directly involved in specific operations.

Any grants, Federal or private or gifts received by State and local government for operating expenses must be offset against allowable costs.

2156.l Unallowable Central Service Costs.--The following expenses are unallowable: (l) general administrative costs of State and local governments-such as the general expenses of State and local governments in carrying out the coordinating, fiscal and administrative functions of government, and public services such as fire, police, sanitation, tax administration and collection, and water, (2) chief executive officer's expenses-the salaries and expenses of the office of the Governor of a State or the chief executive of a political subdivision, (3) legislative expenses--salaries and other expenses of the State legislature or similar local governmental lawmaking bodies such as county supervisors, city council, etc., and (4) tax anticipation warrants and property tax functions.

2156.2 Allocation Bases.--Costs allocated to a provider from a servicing governmental unit must fairly represent benefits received by the provider. Therefore, for the following types of services, the following allocation bases are recommended:

TYPE OF SERVICE	BASIS FOR ALLOCATION
Accounting	Time spend on number of transactions processed
Auditing	Direct audit hours

2202.10 Ratio of Beneficiary Charges for Ancillary Services to Total Charges for Ancillary Services Under the Combination Method.--

A. For cost reporting periods starting before January 1, 1972, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

B. For cost reporting periods starting after December 31, 1971, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges, excluding delivery and labor room charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period, excluding delivery and labor room costs, to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

2202.11 Average Cost Per Diem for Routine Services.--

A. For cost reporting periods starting before January 1, 1972, average cost per diem for routine services means the amount computed by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care (including intensive care but excluding newborn days where nursery costs are excluded from routine service costs)rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

B. For cost reporting periods starting after December 31, 1971, average cost per diem for general routine services means the amount computed by dividing the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other special care inpatient hospital units as well as nursery costs) by the total number of inpatient days of care (excluding days of care in intensive care units, coronary care units, and other special care inpatient hospital units and newborn days) rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

C. Average cost per diem under swing-bed reimbursement.--Reimbursement of routine services furnished in a swing-bed hospital is based on separate average per diem costs for routine long-term care services and general routine inpatient hospital services (see §2230.4 A.)

2206. TOTAL CHARGES

2206.1 Accrual.--A provider's total charges used in the ratio of beneficiary charges to total charges should include all charges for services rendered during the entire cost reporting period. Where a provider does not record its total actual charges on this basis, an accrual must be established to provide for any unrecorded charges. This would also include delayed billing charges, i.e., those charges recorded in a subsequent cost reporting period but applicable to services rendered in the current cost reporting period. A provider should be consistent in the method which is used to establish accrued charges at the end of each cost reporting period. See §2805 regarding apportionment statistics for providers subject to the prospective payment system (PPS).

Where the costs of nonallowable services (e.g., costs of television and radio services for the entertainment of the patients where the equipment is located in patient accommodations) are excluded from allowable costs on the Medicare statement of reimbursable costs, the charges for such nonallowable services for all patients should also be excluded from total charges. Where a provider chooses to include the charges for professional services rendered by hospital-based physicians in Medicare and total charges, these charges must also be accrued. (See § 2204.1.)

2206.2 Late Discharges.--Where a provider imposes a charge for a late discharge, it should include such charges in its total charges for all patients. This is required in order to effect the proper apportionment of costs in the Medicare cost reimbursement formula based on the ratio of Medicare charges to total charges. (For cost reporting periods beginning before January 1, 1972.) (See 2205.3 for an explanation of late discharges for Medicare beneficiaries.)

2206.3 Accommodation Differential - Difference between Semiprivate and Ward.--See § 2204.3, Accommodation Differential.

Cost Apportionment

2207. METHODS OF COST APPORTIONMENT FOR PART A INPATIENT SERVICES

2207.1 Objective.--The law provides that the costs of services to individuals covered by the health insurance program will not be borne by individuals not so covered, and, conversely, that costs of services to individuals who are not under the program will not be borne by the program.

The two methods of apportionment (departmental and combination) available for use in determining the cost of services rendered to beneficiaries of the program have as their goal the allocation of the total allowable costs between the beneficiaries and other patients in as equitable a manner as possible. Under these methods, if it is found that beneficiaries receive more than the average amount of services, the providers would receive reimbursement greater than the average cost for all patients. Conversely, if the beneficiaries receive less than the average amount of services, the providers would be reimbursed accordingly for the services rendered.

2208. METHODS OF COST APPORTIONMENT FOR ALL-INCLUSIVE RATE OR NO-CHARGE STRUCTURE PROVIDERS

2208.1 All-Inclusive Rate or No-Charge Structure Hospitals.--The approved methods for apportioning allowable cost between Medicare and non-Medicare patients under the program are not readily adaptable to those hospitals having an all-inclusive rate (one charge covering all services) or a no-charge structure. Therefore, alternative methods of apportionment have been developed for all-inclusive rate or no-charge structure hospitals. These methods are available only to those hospitals which do not have charge structures for individual services rendered. The alternative methods described herein are presented in the order of their preference, A through E.

For cost reporting periods ending before January 1, 1970, the statistical method (Method A) should be used where there are sufficient and usable data available. Alternative Methods B through E are offered to accommodate the varying degrees of data available in these hospitals. The use of Methods B through E must be approved by the intermediary after considering the data available and ascertaining which of the methods that can be applied achieves equity, not merely greater reimbursement, in the allocation of costs for services rendered to Medicare beneficiaries.

For cost reporting periods ending after December 31, 1969, the statistical method (Method A) shall be considered the permanent method of cost apportionment. Where the permanent method is not used, the intermediary may grant specific permission for a hospital to continue to use--on a temporary basis--a less sophisticated method.

Having used an alternative of higher preference, a hospital may not elect to use an alternative of lower preference in subsequent reporting periods. For example, if a hospital used Method D, Comparative Hospital Data, for its first reporting period, it cannot, thereafter, elect to use alternative Method E. It can, however, use methods A, B, or C. Where the statistical method is not used, the intermediary will add to the cost report a statement explaining why the method selected was used, and why methods of higher priority could not be used.

In the application of these alternatives, cost report forms plus associated instructions and definitions currently in use should be used where applicable.

A. Departmental Statistical Data-Method A.--In the absence of charge data which would permit the use of methods approved under §§ 2200.1-2200.3, this method is to be used where adequate departmental statistics are available. The step-down procedures for cost finding required in § 2306.1 must be used.

Under the statistical method, the cost of routine services are apportioned on the basis of the relative number of patient days for beneficiaries and for other patients, i.e., an average per diem basis. The costs of ancillary services if apportioned departmentally on the basis of the ratio of covered beneficiary inpatient statistics to total inpatient statistics applicable to such costs. Statistics must be weighted to reflect relative values. Since weighting factors may vary among various types of institutions, the intermediary may approve the use of those factors which in its judgment produce the most equitable results in each situation. In any event, the data collected must satisfy audit verification. The amounts computed as the program's share of the provider's routine and ancillary costs are then combined in determining the amount of program reimbursement.

Application.--Hospitals that have maintained a count of services by type rendered to Medicare and non-Medicare patients may apply such statistics in the apportionment of ancillary costs. Hospitals that did not record such statistics during their first Medicare cost reporting period may use statistical sampling techniques where approved by the intermediary. However, hospitals that began to record such statistics during the second cost reporting period may use the statistical data gathered in the second period to apportion costs of the first period. In such cases,

however, the intermediary must have established that procedures followed in gathering data are proper. The statistics must represent an adequate segment of the period in which gathered, preferably 6 months or longer.

Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients. For example, a provider may have very limited physical therapy services which may represent less than 1 percent of the total direct and indirect costs and therefore a separate cost apportionment is not necessary. Other ancillary services such as regular drugs and medical supplies may be significant but present special difficulties in identifying and measuring usage. For cost reporting period ending before January 1, 1970, the total expenditures for such services can be segregated and assumed to have been incurred by Medicare and non-Medicare patients in equal quantity per patient day. The cost of these ancillary average cost per diem for all patient multiplied by the total number of Medicare patient days. For period ending after December 31, 1969, where such services are significant, adequate procedures must be established for measuring the use of these services by Medicare beneficiaries.

Using the statistical basis the cost settlement shall be determined as follows:

1. Determine total allowable cost using Form SSA-1562, Schedule A through Worksheet B-1-2.

2. Complete Schedule C and C-1 Form SSA-1562 to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

3. Multiply the average per diem cost of routine services by the total Medicare days, or apply the ratio of Medicare inpatient charges to total inpatient charges to total inpatient routine services costs to determine Medicare's share of routine service costs.

4. Determine the Medicare portion of ancillary costs by applying departmentally, the statistical ratio of Medicare utilization to total utilization. Such statistical data may be shown on the "Calculation of Reimbursement Settlement, Inpatient Services," Form SSA-1563, page 2, for cost reporting periods ending before April 1, 1968, or Exhibit B, Form SSA-1992 for cost reporting periods ending after March 31, 1968.

5. The statistics used in 4 above should be supported by a supplementary schedule showing how they were developed.

2208.3 Determining Cost of Inpatient Ancillary Services Covered Under Part B for Medicare Beneficiaries in Hospitals and Skilled Nursing Facilities with All-Inclusive Rate or No-Charge Structure.--The cost of inpatient ancillary services, which are rendered to hospital or skilled nursing facility inpatients and which are covered under Part B when the level of care becomes noncovered or when Part A benefits become exhausted or are otherwise not payable, must be determined in accordance with the provisions of this section. These ancillary services include radiology, pathology, electrocardiology, electroencephalography, physical therapy (effective October 30, 1972), speech pathology (effective January 1, 1973), renal dialysis (effective July 1, 1973), and prosthetic devices, braces and splints covered under the heading of medical supplies.

Section 2208.1, applicable to hospitals, and section 2208.2, applicable to skilled nursing facilities, prescribe the cost apportionment methods for computing the cost of services which are rendered to Medicare inpatients and which are reimbursable under Part A. Accordingly the methodologies to be used in determining reimbursable Part B inpatient ancillary service costs are dependent upon which of the cost apportionment methods available to all-inclusive rate or no-charge structure providers are employed. These methods are described below.

The procedures outlined in this section have not been specifically directed towards the all-inclusive rate and no-charge structure hospital skilled nursing facility complex. Components of these provider complexes should use the apportionment methods which have been approved by the intermediaries within the guidelines of §§ 2208.1-2208.2. In addition, intermediaries shall adapt the procedures outlined in this section to these provider complexes to assure that reimbursement is equitable. In so doing, such providers should use the form SSA-9554 exhibits which are comparable to the exhibits and schedule of forms SSA-1751 cited throughout this section.

A. Departmental Statistical Data-Method A or Method I.--(For use by hospitals or skilled nursing facilities.) Part A ancillary service costs under this apportionment method are determined by use of statistical data accumulated separately for each department.

To determine the Medicare portion of Part B inpatient ancillary service costs, it will be necessary to accumulate Medicare departmental statistical data, using the same bases as those used for the same ancillary services in determining the Part A costs. Such Medicare statistical data will be

applicable to those beneficiaries covered under Part B when Part A benefits are not payable. the ratio of statistics for Medicare Part B inpatients to total statistics for all inpatients, by department, will be applied to the total allowable inpatient cost for that department to determine the cost which is reimbursable under Part B.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined for hospitals in § 2208.1 or for skilled nursing facilities in § 2208.2.

b. Use the ratio of Medicare Part B inpatient statistics to total statistics for all inpatients, by department, to determine the Medicare portion for Part B inpatient ancillary costs. Substituting statistics for charges, this determination may be made on Exhibit F of form SSA-1992. Both hospitals and skilled nursing facilities may use Exhibit F.

c. For hospitals, the total amount applicable to Medicare, which is computed on Exhibit F, column 5, line 7, should be inserted on Form SSA-1992, Exhibit E, column 2, line 6a. For skilled nursing facilities, this amount should be added to the amount computed on Form SSA-1751, Schedule D-2, line 5. The caption on this line should be modified to indicate that such costs are included therein. Also, insert the amount computed on Exhibit F, column E, line 7, to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" on line 5 will be the product of line 4 multiplied by line 3, plus the amount entered to left of the "Part B column."

B. Sliding Scale--Method B.--(For use by hospitals only.) Under this method, an adjusted average per diem Part A ancillary cost applicable to Medicare inpatients is determined by applying to the ancillary service average per diem cost a weighted percentage, which takes into account the longer lengths of stay of aged patients.

The following percentages represent the average ratio of inpatient ancillary service costs, which would be reimbursable under Part B when Part A benefits are not available, to total inpatient ancillary service costs.

All Hospitals Except Psychiatric	45%
Psychiatric	48%

The reimbursable Part B ancillary cost applicable to Medicare inpatients shall be the appropriate percentage times the adjusted average per diem Part A ancillary cost for Medicare inpatients.

Assuming the provider is a short-term hospital, the following illustrates this method for computing the Part B inpatient ancillary service:

2600. PRINCIPLE

For cost reporting periods beginning after December 31, 1973, reimbursement to providers for services to Medicare beneficiaries will be based upon the lower of the reasonable cost of providing those services or the customary charges for the same services. However, in the case of hospital Part A services, this provision will not apply to cost reporting periods beginning on or after October 1, 1982, for any hospital that is subject to the rate of increase ceiling under section 1886(b) of the Social Security Act. The lower cost or charges provision also will not apply with respect to hospital Part A services furnished by a hospital that is subject to the prospective payment system, pursuant to section 1886(d) of the Act for cost reporting periods beginning on or after October 1, 1983. (Providers entitled to recapture previously disallowed costs will continue to be able to do so during this time.)

Payments to providers will be based on the interim rate which approximates reasonable cost as nearly as practicable, but cannot exceed 100 percent of the customary charges for the same services. (See §2406.)

This principle will be applicable to services rendered by providers other than those public providers (see§2604.2) that render services free of charge or at a nominal charge. When such public providers render services to beneficiaries, they will be paid full reasonable cost for those services. (See §2616.)

The lower of cost or charges principle does not apply to SNF-type services furnished in a swing-bed hospital (see §2230.3A). This principle also does not apply to SNF services furnished to inpatients of a distinct part SNF which is part of a qualified small, rural hospital complex that has elected the optional reimbursement method. (See §2230.5)

2602. APPLICATION

Application of the lower of reasonable cost or customary charges provision requires that a comparison be made between the total reasonable cost and the total customary charges of the items or services furnished Medicare beneficiaries. In comparing charges and cost, all customary charge for items and services and the reasonable cost of such items and services will be aggregated without regard to whether the related provider services are reimbursable under Part A or Part B of title XVIII. (See §2610.)

In a cost reporting period where a provider's aggregate customary charges are less than its aggregate reasonable cost, payment to that provider will be based on its charges. However, under certain circumstances, a provider may carry forward its unreimbursed reasonable cost for reimbursement in a subsequent cost reporting period. Amounts carried forward may be reimbursed in the next two succeeding period. Amounts carried forward may be reimbursed in the next two succeeding periods, but only to the extent total customary charges exceed total reasonable cost in each subsequent period. (See §2614.)

2604. DEFINITIONS (Also see §2402.)

2604.2 Public Providers.--A public provider means any provider owned by a Federal, State, county, city, or other local government agency or instrumentality. This definition includes facilities owned jointly by two or more Government entities but does not include facilities owned jointly by Government and private organizations.

2604.3 Customary Charges.--Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined "customary charges" are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of "patients liable for payment on a charge basis." Such charges must also be recognized for program reimbursement.

A. Imposed Uniformly on Most Patients.--To be considered "customary" for Medicare reimbursement, a provider's charges for like services must be imposed on most patients regardless of the type of patient treated or the party responsible for payment of such services.

2. Stratification of Collections from "Patients Liable for Payment on a Charge Basis.--The provider's accounts receivable record should indicate the party responsible for payment and similar classification should be identifiable within those records. The provider should segregate and analyze the changes to those individuals "liable for payment on a charge basis" as described in 1 above. The analysis should identify the patients, the charges, amounts collected, bad debts, etc.

3. Bad Debts and Indigency Allowances of "Patients Liable for Payment on a Charge Basis.--Where bad debts and/or indigency allowances constitute the provider's reason for not collecting the charges imposed from its established charge schedule, reasonable collection efforts must be made by the provider, within the criteria set forth in §§310 and 312, these charges to be considered "customary charges." (Public providers, see § 2606.2E.)

2604.4 Nominal Charges.--A public provider's charges are considered nominal where the aggregate customary charges (see § 2604.3) are less than one-half of the reasonable cost of services or items represented by such charges. Nominal charges are charges which are usually token in nature and not intended to be full reimbursement for the items or services furnished.

Determination and Comparison of Customary Charges and Reasonable Cost

2606. DETERMINATION OF CUSTOMARY CHARGES FOR COMPARISON WITH REASONABLE COST (see § 2604.3.)

Each provider and subprovider must separately make a determination of its customary charges; for example, when a hospital and its distinct-part SNF are both participating providers, each must make such a determination of customary charges for its own operation.

Where a provider imposes its charges uniformly and actually collects its charges from a substantial percentage of "patients liable for payment on a charge basis", the provider's charges, whether from an established schedule or its most frequent or typical charge, are considered to be its customary charges. These should be compared to reasonable cost, as provided for in § 2612, to determine the amount of Medicare reimbursement.

However, where a provider does not actually impose its charges uniformly or fails to make a reasonable effort to collect its charges from a substantial percentage of "patients liable for payment on a charge basis" (see § 2604.3B), the provider's charges, whether from an established schedule or its most frequent or typical charges, are not considered to

Example No. 3

A. An analysis of charges disclosed the same information described in Example No. l above.

B. An analysis of collections from "patients liable for payment on a charge basis" disclosed the following:

l. The individuals with private insurance made only partial payment of the charges imposed. This payment was accepted by the provider as full payment for services rendered the covered patients with no further collection efforts employed.

2. The remainder of the "patients liable for payment on a charge basis" had no insurance coverage, and the difference between charges and collections was due to bad debts even though reasonable collection efforts were employed by the provider.

C. Customary charges for comparison with reasonable cost are computed as follows:

$$\$100{,}000 \times \frac{\$270{,}000 + \$10{,}000(*)}{\$300{,}000} = \$93{,}330$$

(*) Represents bad debts where reasonable collection effort has been made.

2606.2 Treatment of Providers with Special Charge Structures.--The methods for determining customary charges for providers which have special charge structures are as follows:

A. No-Charge Structure.--Generally, if a provider other than a public provider does not charge for services rendered in the delivery of health care services, there are no customary charges related to such services, and the Medicare program will not reimburse for such services. Public providers, which furnish services free of charge, are reimbursed the reasonable cost of services.

B. All-Inclusive Charge Structure.--If an "all-inclusive rate" structure is uniformly applied to all patients, those charges may be used for determining customary charges under the lower of cost or charges provisions. An "all-inclusive rate" is generally:

l. A single rate for all services based on:

a. A per diem rate, or

b. Patient's illness, injury or type of treatment, or

c. The type of accommodation.

2. A single rate for most services with separate charges for a very small number of separate specialized services.

Some providers using an "all-inclusive rate" may be public providers and will be reimbursed reasonable cost if their charges are less than 50 percent of the cost of delivering health care services.

C. Descending-Rate Charge Structure.--The descending-rate is predicated upon the length of patient stay; that is, the longer the patient stays, the lower the charge per day (regardless of the type of service rendered). If the descending-rate charge structure is uniformly and consistently applied to all patients, these charges will be considered the customary charges for purposes of this section.

D. Sliding-Scale Charge Structure.--Some providers offer free care or care at a reduced charge to patients who are determined to be financially indigent. This practice may reflect the provider's written policies or the requirement of a Hill-Burton agreement to provide free care. In such cases, the charge assessed the patient is based on the patient's ability to pay. Under program guidelines, the difference between the provider's full published charges and the charge actually assessed the patient is considered an indigency allowance. To assure that the provisions of such free are or care at a reduce rate will not affect the acceptance of the provider's established charge schedule as customary (public providers, see § 2606.2e), the following conditions must be met:

1. The provider must have a published schedule of its full (nondiscounted) charges.

2. The provider's revenues for patient care must be based on application of the published charge schedule.

3. The provider must maintain written policies for its process of making patient indigency determinations.

4. The provider must maintain sufficient documentation to support the amount of "indigency allowances" written off in accordance with the above procedures.

E. Public Providers with a Sliding Scale Charge Structure.--Some public providers establish a sliding-scale structure pursuant to a legal requirement imposed by a State or local government or as a condition of a Federal grant or loan. This requirement stipulates that the charge billed must be based on the patient's or responsible party's ability to pay or it may require the provider to render free care to medically indigent patients.

A public provider with a legally-required sliding-scale charge structure may elect to determine Medicare aggregate customary charges by : (1) meeting the conditions in § 2606.2D so that its full rate from its established charge structure will not be affected, or (2) applying the formula contained in § 2406.1A, or (3) applying the ratio of the actual charges billed to patients liable for payment on a charge basis (non-contractual patients) based on the sliding scale, to the adjusted charges to noncontractual patients based on the charge schedule used to record charges on bills submitted for program reimbursement applied to Medicare aggregate charges, or the ratio of billed charges to non-contractual patients to total charges recorded for noncontractual patients applied to Medicare aggregate charges.

EXAMPLES:

Option 3 (1st Alternative)

1a--Medicare aggregate charges	$ 500,000
b--Actual charges to noncontractual patients based on sliding scale	200,000
c--Adjusted charges to noncontractual patients based on the charge schedule used to record charges on bills submitted for program reimbursement	1,000,000
2a--Actual charges (line 1b)	$ 200,000
b--Adjusted charges (line 1c)	1,000,000
c--Ratio of a + b	20%
3a--Medicare aggregate charges (line 1a)	$ 500,000
b--Ratio (line 2c)	20%
c--Medicare aggregate customary charges	$ 100,000

Option 3 (2nd Alternative)

1a--Medicare aggregate charges	$ 500,000
b--Total charges recorded for noncontractual patients before medical indigency allowances	1,000,000
c--Medical indigency allowances	800,000
2a--Total charges (line 1b)	$1,000,000
b--Medical indigency allowances (line 1c)	800,000
c--Billed charges	$ 200,000
3a--Billed charges (line 2c)	$ 200,000
b--Total charges (line 1b)	1,000,000
c--Ratio of a - b	20%
4a--Medicare aggregate charges (line 1a)	$ 500,000
b--Ratio (line 3c)	20%
c--Medicare aggregator customary charges	$ 100,000

2612. COMPARISON OF CUSTOMARY CHARGES AND REASONBLE COST

Application of this provision requires each provider and subprovider to make a comparison between the customary charges and the reasonable cost, as described in the related preceding subsections. Consequently, a hospital with a distinct-part SNF, where both are participating providers, must make separate determinations for the hospital and for the SNF as to which is lower--its customary charges or its reasonable cost.

made after the current basis for payment has been determined, i.e., reasonable cost or customary charges.

C. Payments to funds for donated services of teaching physicians.

D. Administrative costs incurred after a provider terminates participation in the Medicare program and which are included in the final cost report as provided for in §2176.

E. Costs representing unanticipated extraordinary expenditures made by a provider immediately following the end of the provider's final cost reporting period for unemployment compensation paid to former employees. The unemployment must be en masse and attributed to the provider's simultaneous cessation of operations and termination of program participation. The cost must be properly includable in the provider's final cost reporting period based on its system of accounting for such costs.

F. Costs incurred by a provider before cessation of operations and termination of program participation, but which are represented by a subsequent lump-sum pension plan payment related to the employees' prior services to the provider. The subsequent lump-sum payment must be caused by the cessation of operations and the provider must be legally required to make such payment.

G. Reasonable accrued severance pay due to a provider's cessation of operations and termination of program participation. Severance payments made to individual employees in an ongoing operation are not excluded from the comparison of reasonable cost to customary charges.

Reasonable cost, for comparison with customary charges, should include the allowance for return on equity capital permitted for proprietary providers as provided for in Chapter 12.

After all exclusions and limitations have been applied to otherwise reasonable and allowable costs, including the specific adjustments mentioned above, the remaining reasonable cost should be compared to customary charges as described and illustrated in §2612. Adjustments to reasonable cost other than those specified above may not be made.

2610. AGGREGATION OF CHARGES

For purposes of determining payment under the lower of cost or charges provision, the provider should aggregate its customary charges for all items and services furnished Medicare beneficiaries regardless of whether the related items or services are covered under Part A or Part B of title XVIII. In order to be comparable to these customary charges, the reasonable costs for items or services furnished Medicare beneficiaries should also be aggregated without regard to whether those costs would be reimbursable under Part A or Part B. Customary charges and reasonable cost are subject to the adjustments described in §§2606 and 2608, respectively, prior to their comparison. In addition to those adjustments, however, the provider should assure itself that it has reduced both its charges and costs for (1) the professional component (see §2108) of its provider-based physicians, and (2) all items and services not covered by Medicare.

See the FACTS for examples in §2612 for an illustration of the aggregation of charges for comparison with reasonable cost.

Total Medicare Payment

Total Medicare reasonable cost	$687,000
Amount of Cost Limitation carryover actually recovered (maximum available $5,000, maximum applicable this period $3,000)	$ 3,000
Subtotal	$690,000
Amount of Lower of Cost or Charges carryover actually recovered (available $7,000 maximum, if available, $13,000, less actual Cost Limitation carryover $3,000 recovered equals $10,000)	$ 7,000
Total Medicare payment*	$697,000

*Less: Interim payments, etc. already paid by Medicare to its beneficiaries.

Amounts available for carryover (To Next Reporting Period)

Cost Limitation ($5,000 Less recovery of $3,000)	$ 2,000
Lower of Cost or Charges ($7,000 less recovery of $7,000)	$ - 0 -

Public Providers

2616. PUBLIC PROVIDERS

A public provider, as defined in § 2604.2, with a no-charge or a nominal-charge structure will receive payment for items or services furnished Medicare beneficiaries based on reasonable cost. Only a pubic provider with a no-charge or nominal-charge structure, as defined in § 2604.4, is exempted from the lower of cost or charges application. When a public provider does not charge for services furnished, there is no basis for making the comparison and payment to such a provider will be the reasonable cost of providing such services. However, when a public provider imposes nominal charges for services furnished, a comparison of the provider's aggregate customary charges and aggregate reasonable cost (see § 2614) shall be performed to determine the basis for payment.

If the comparison substantiates the charges as being nominal, i.e., less than 50 percent of reasonable cost, the public provider will be entitled to payment of the reasonable cost, the public provider will be entitled to payment of the reasonable cost for such services. On the other hand, if the aggregate charges are determined to be other than nominal, the provider will receive payment based on the lower of its customary charges or reasonable cost. Where a public provider is reimbursed on the basis of charges, it is entitled to utilize the carryover recovery provisions set forth in § 2614.

ATTACHMENT C - RFP #720C-04325-12DOO

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES 11/1/2011

ANALYSIS OF MEDICARE AND MEDICAID PATIENT DAYS

FROM 6/30/2011 COST REPORT

COMPONENT	MEDICARE A DAYS	% TOTAL	MEDICAID DAYS	% TOTAL	TOTAL DAYS	TOTAL % MEDICARE & MEDICAID	TOTAL % OTHER PATIENT DAYS
MEDICAL SURGICAL							
ESH	508	70.8%	4	0.6%	718	71.3%	28.7%
WSH	34	31.2%	0	0.0%	109	31.2%	68.8%
SWVMHI	101	13.1%	6	0.8%	769	13.9%	86.1%
HDMC	0	0.0%	0	0.0%	137	0.0%	100.0%
CVTC	246	97.6%	6	2.4%	252	100.0%	0.0%
SUB-TOTAL	**889**	**44.8%**	**16**	**0.8%**	**1,985**	**45.6%**	**54.4%**
SKILLED NURSING							
ESH	0	0.0%	0	0.0%	0	0	0.0%
CVTC	211	0.7%	29,686	98.3%	30,196	99.0%	1.0%
HDMC	39	0.2%	12,630	74.5%	16,955	74.7%	25.3%
SUB-TOTAL	**250**	**0.5%**	**42,316**	**89.7%**	**47,151**	**90.3%**	**9.7%**
INTENSIVE PSYCHIATRIC TRTMT							
WSH	3,688	22.2%	0	0.0%	16,647	22.2%	77.8%
ESH	95	0.7%	0	0.0%	13,406	0.7%	99.3%
NVMHI	2,191	5.2%	0	0.0%	42,013	5.2%	94.8%
SWVMHI	3,466	13.4%	0	0.0%	25,915	13.4%	86.6%
SVMHI	1,418	7.8%	0	0.0%	18,172	7.8%	92.2%
SUB-TOTAL	**10,858**	**9.3%**	**0**	**0.0%**	**116,153**	**9.3%**	**90.7%**
CHRONIC DISEASE							
CATAWBA	3,512	17.5%	15,280	76.1%	20,069	93.6%	6.4%
PIEDMONT	262	0.7%	25,213	62.8%	40,178	63.4%	36.6%
SUB-TOTAL	**3,774**	**6.3%**	**40,493**	**67.2%**	**60,247**	**73.5%**	**26.5%**
INTERMEDIATE CARE FAC.-GEN							
ESH			16,450	32.9%	50,076	32.9%	67.1%
SWVMHI			4,631	67.9%	6,816	67.9%	32.1%
HDMC			2,562	62.2%	4,116	62.2%	37.8%
SUB-TOTAL			**23,643**	**38.8%**	**61,008**	**38.8%**	**61.2%**
INTERMEDIATE CARE-MR							
SVTC			90,008	100.0%	90,008	100.0%	0.0%
CVTC			111,935	98.8%	113,284	98.8%	1.2%
SWVTC			66,143	99.4%	66,511	99.4%	0.6%
NVTC			57,096	99.4%	57,435	99.4%	0.6%
SEVTC			44,598	96.8%	46,084	96.8%	3.2%
SUB-TOTAL			**369,780**	**99.1%**	**373,322**	**99.1%**	**0.9%**
GRAND TOTAL	**15,771**	**2.4%**	**476,248**	**72.2%**	**659,866**	**74.6%**	**25.4%**

ATTACHMENT D - RFP #720C-04045-06D

SWAM Subcontracting Expenditures

The amount spent by prime contractors with DMBE certified SWAM businesses for work directly traceable to the fulfillment of a contract with the agency.

Total Subcontracting Expenditures with MBE	**Total Subcontracting Expenditures with WBE**	**Total Subcontracting Expenditures with SBE**
$	**$**	**$**

Name of Subcontractor	Federal Tax ID	MBE, WBE or SBE	Contract Number	Dollar Amount

Attach lists of names of subcontractors, Federal Tax IDs, SWAM designation, Your Contract Number (if applicable), and expected contracted amounts to the subcontractors.